MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, December 13, 2001
10:00 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
BEATRICE S. BRAUN, M.D.
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
ALLEN FEEZOR
FLOYD D. LOOP, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
JANET G. NEWPORT
CAROL RAPHAEL
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

Agenda item:
Quality improvement for health plans and providers
-- Karen Milgate, Mary Mazanec

P R O C E E D I N G S

MR. HACKBARTH: I'd like to welcome our guests. Please have a seat as quickly as possible since we're going to go ahead and start.

The first item on our agenda this morning is quality improvement for health plans and providers. This is a mandated study that we've discussed several times now. The purpose of our discussion today is to vote on our final recommendations. Mary, Karen?

DR. MAZANEC: Thank you. Today we will focus on the revised draft recommendations and report for the quality improvement standards in the Medicare program. At this meeting we are asking the commissioners to comment on the content of the revised report and to come to closure on the recommendations.

I will begin by briefly recapping our analysis and findings and then Karen will discuss the recommendations.

As you recall, in the BBRA, Congress directed MedPAC to look at how Medicare should apply quality improvement standards to the fee-for-service in the Medicare+Choice programs. At the October meeting, we presented our analytical approach and findings and I just want to briefly summarize that right now.

As you recall, our analysis consisted of three parts. First, we identified the goals of quality improvement standards and then examined the manner in which they are applied by private accreditors, regulators, and purchasers. Next, we analyzed the M+C standards and the QI efforts in the fee-for-service program. And finally, we evaluated the feasibility of applying standards comparable to the M+C standards to each type of plan and provider.

Based on our analysis, we had four major findings which are summarized on this slide. First, we concluded that providers and plans have varying capacities to comply with quality improvement standards. At present, only HMOs can fully meet all of the M+C requirements. Second, oversight and private and public purchaser efforts are often duplicative. We see this duplication in both the application of process and structure standards and in the development of measures. Deeming status may actually ease this problem. Third, rewarding or assisting providers or plans may further stimulate quality improvement. And finally, more research is needed, especially on measures and the most effective ways to stimulate quality improvement.

At the last two meetings in October and November, we heard a lot of different things from the commissioners. From their discussion, we identified four broad considerations that guided us in writing the draft recommendations. These considerations are listed on this slide.

First of all, beneficiaries should receive high quality care, whether they choose the fee-for-service or the M+C program. Quality improvement efforts are imperative and Medicare should lead these quality improvement efforts. Finally, all plans and providers should work to improve quality in accordance with their capabilities.

Now Karen will talk about the draft recommendations.

MS. MILGATE: As Mary said, Congress asked us to advise them on how to apply quality improvement standards. The three draft recommendations in front of you include guidance specifically on how to apply standards, but also suggest that quality improvement standards should be applied in a broader context that includes other strategies to stimulate quality improvement.

Today we will be presenting three draft recommendations, but this slide really sums up the principles that we heard in the discussions at the last two meetings that underline all of these recommendations and we wanted to put them out explicitly before talking about the recommendations themselves.

First, that Medicare should take into account the differing capabilities of plans and providers when applying standards and apply standards flexibly to account for those.

Second, that Medicare should reward exemplary performance and quality improvement whether as a result of voluntary efforts or mandatory requirements.

Third, that Medicare should seek to reduce oversight duplication when developing and applying standards and coordinate and build on private sector oversight efforts.

Fourth, that recognizing there are gaps in the ability for different providers and plans to actually measure and improve care, that Medicare should assist providers and plans in performing quality improvement.

And finally, that recognizing that gaps occur in the knowledge about how to actually do quality improvement, that one role for Medicare is to, along with others such as ARC, research quality improvement measures and strategies.

These are the principles that we felt where there was general agreement within the Commission. The area where there seemed to be discussion was on what the appropriate level of quality improvement standards should be. So that's the primary discussion we would hope to have today.

So what we decided to do in presenting the recommendations is actually present recommendations two and three first, since those are the ones where there seem to be more general agreement, and then save the description of the discussion of recommendation one for last.

Draft recommendation two states that the Secretary should reduce duplication between public and private oversight efforts when applying quality improvement standards and measures. The report discusses several strategies for reducing duplications, however the two primary ones are in Medicare+Choice to make broader use of deemed status. Because the predominant form of Medicare+Choice plan at this time are HMOs, and many HMOs are already accredited in the private sector, this could help lessen their burden and potentially reduce the unevenness between the playing field between HMOs and non-HMOs.

In the fee-for-service program, because deemed status is much more developed, the issue is more a matter of standardization of measures. Many different private and public sector purchasers are considering, and in some cases already requiring institutional providers to report on core measure sets. And so this recommendation suggests that Medicare should participate in coordinating those efforts and to try to make sure that the measures they use are as close as possible to any private sector measures.

Draft recommendation three combines two of the principles I spoke about earlier. The first is that the Secretary should assist plans and providers to improve quality. The second is that he should also encourage and fund research on appropriate measures and effective mechanisms to improve quality.

The first part addresses the gap I spoke about earlier and the ability for providers and plans to improve quality and suggest that Medicare should help close this gap by providing technical assistance in such areas as collection and analysis of data, advice on effective mechanisms, and also potentially dissemination of best practices among providers and plans.

The second part recognizes the gaps in knowledge about effective mechanisms in measures and some of the report text talks about studying measures in areas where less is known about how to measure quality, looking at incentives, both that we might suggest at the plan or institutional provider level but also within, to work with physicians. And one of the other major barriers where it seemed there needed to be more research is in looking at appropriate risk adjustment methodologies to make it easier to publicly report information on individual providers.

This slide and the next one are both draft recommendation

one. Between the discussion at the last meeting and responses to e-mails in between, staff have identified basically two options with which various commissioners agreed. We don't have actually option 1B or 1C here. When we put the options next to each other, we realized that, in fact, there were two concepts where there was general agreement between those options. And then a couple of others that could add in or not add in, depending upon how the Commission would discuss at this meeting.

So the first slide here are the two concepts within draft recommendation one which we felt were generally agreed upon. And then the second one is identifying areas of potential disagreement.

The first one in which we thought there was general agreement was that the Secretary should recognize differing plan and provider capabilities when developing and applying quality improvement standards and rewarding exemplary performance.

Just to address quickly, Alan, your point on this, it probably is implied in the concept of applying quality improvement standards that you would take into consideration those different capacities when rewarding exemplary performance. We actually added in those words, which ends up looking kind of redundant, just to be more explicit. So that's something we'd be glad to have some discussion on. It seemed like that was potentially your issue with that concept.

And this, just to go over it again, recognizes that collecting and analyzing data and influencing quality is done different in different organizations. For example, PPOs have less ability to abstract information from medical records. Small institutions may have less ability than large institutions. And data may be more valid on one type of provider or plan than another.

The second concept with which we felt there was general agreement was that the Secretary should reward plans and providers for exemplary quality improvement performance. At the last meeting, staff actually presented this as a separate recommendation but we heard from the Commission that, in fact, you felt that that needed to be a central piece of the strategy for applying standards and the rationale that we heard was that it was seen as a way to reward those who may, in fact, have more vigorous standards applied to them and perhaps lessen the distinctions between, for example, HMOs and non-HMOs.

And it was also seen as a more appropriate strategy for stimulating quality improvement than perhaps applying additional standards.

The last two concepts address the level of standards to be

applied. On these two we felt like we heard a differing of opinion at the last meeting and wanted to highlight the two options and suggest what we heard in terms of arguments for and against. So I'll present some pros and cons to these.

The first concept is that the Secretary should eliminate the requirement for HMOs to demonstrate quality improvement on the two QAPI projects. Those who thought this concept should be included suggest that this was one way to create a more level playing field between HMOs and non-HMOs in the Medicare+Choice program, and that it was inappropriate to have differing levels of standards in that program.

Those who didn't think it should be included, or that it was necessary to include it, suggested that it was appropriate to apply different standards, that in fact HMOs do do more and have more capacity to manage care. And simply because PPOs aren't able doesn't mean that you should take the standards off the HMOs. And further suggested that perhaps you could rely on rewards and some of the lessening of burden through deemed status to reduce that unlevel playing field.

Just a note, this one and the other one can be achieved through regulation. So let's be clear on that. there's no need to change statute for either of these to be included.

The second concept with which we felt there was some discussion necessary was that the secretary should apply quality improvement requirements comparable to those in Medicare+Choice programs to institutional providers in the fee-for-service program. Those who felt this should be included suggested this will create a more level playing field between fee-for-service and Medicare+Choice and if indeed many of these activities are already occurring it would not be a significant undertaking for CMS to require this level of standard or for providers to actually meet those standards.

Those who didn't think it was necessary to include it but suggest that these activities are already ongoing, that it wasn't necessary to require them if they're happening on a voluntary basis and unless there was some suggestion that there wasn't enough quality improvement going on in the fee-for-service program. Once again, it might be possible to rely on the concept of rewarding high performers and a lessening of the duplication to reduce the unlevel playing field, so to speak, between Medicare+Choice and fee-for-service.

That is the presentation. We, of course, would appreciate comments generally, but specifically in this area. And we would also note that the draft that you have of the report was revised to include some of the other, more general comments that we heard

at the last meeting. Specifically, we added a section on the cost impact of quality as well as the evolution of the science of quality improvement.

MR. HACKBARTH: Help me manage the time effectively here. What Mary and Karen have presented is their belief that we've got broad areas of agreement and a couple of specific areas where there may be some disagreement. To be specific, they heard consensus on recommendations two, three and the first page of one. Did they hear correctly? If so, what I would like to do is initially focus on the areas of disagreement so we can make sure that we discuss those thoroughly and not waste our time on nuances.

DR. NEWHOUSE: Just one issue with the second bullet under one, which is --

MR. HACKBARTH: So the first page of one?

DR. NEWHOUSE: Yes, the reward plans and providers for exemplary quality improvement performance. There was a principle on an earlier slide that had reward high performance. And this only talks about improvement. So the question is if I've got a plan where already 95 percent of the AMI patients are getting beta blockers, does it not get a reward?

MS. MILGATE: The three concepts that I would throw out as important in looking at what you would reward would be one, the one you just mentioned, where you have a high standard, like 80 percent get beta blockers. And you're at 90, so that's a standard that somebody set.

Another concept would be if you start down at a low level, say you're at 50 percent, the standard that is set is at 80, that if you actually get it up to 75 that's a pretty significant jump.

And then the third, that would recognize innovation and make sure that people aren't just going for the low-hanging fruit, is perhaps to reward innovative projects. So those are three different concepts that could probably be captured under the words high, if you prefer that word.

MR. HACKBARTH: Why not, Karen, just reward high performance?

MS. MILGATE: I think that's fine. I think all three of those could be captured under the words high performance.

MR. HACKBARTH: I'd like to just stay with this issue for a second. The question that is on the table that Joe has raised is rewarding only high performance versus maybe high performance plus improvement plus innovation.

DR. NEWHOUSE: It rewards only improvement as it's currently worded.

MR. SMITH: Joe, I think what you say logically makes sense,

but what troubles me here, thinking about beneficiaries, beneficiaries in low performing institutions and plans that do a lot of improvement are a lot better off than beneficiaries already receiving exemplary care.

If what we're trying to think about here is how do we use incentives and rewards in order to make high quality care more available to more beneficiaries, throwing more resources at institutions and plans that are already performing well doesn't accomplish that.

I understand the distinction that you draw, but I'm not sure what the consequences of it are.

DR. STOWERS: I'm not trying to be redundant but I think it's important to have both of those in here. We've got to obviously reward those that do quality improvement, but there's lots of rewards other than just financial for those that have already accomplished the high level of performance. That could be decreased regulatory burden or whatever.

So I think it's important to get the message across here, that the rewards should be for both of those. So I agree with Joe entirely.

DR. BRAUN: I agree with Joe too, because actually I don't think beneficiaries are better off or as well off if there is a plan that's going 50 to 75 than they are with one that's already at 95, because they are obviously getting better care.

MR. HACKBARTH: So you're saying that you would reward both improvement and high performance?

DR. BRAUN: Yes.

DR. NEWHOUSE: If it's just improvement, I don't know what happens if I go from 50 to 75 and then back to 50 and come then back up to 75. Do I collect money every other year or what? I don't know how to handle that.

DR. REISCHAUER: I was going to make a related point which is, you can't get improvement payments year after year without getting the high quality, presumably. So there has to be some rather complicated reward formula here. But it should have penalties, as well.

MR. HACKBARTH: Can we just do a straw vote here? The proposal on the table from the staff was to reward a mixture of high performance, improvement, and innovation, as I understood it.

Let's just do a straw vote. How many favor that approach?

DR. REISCHAUER: Can I ask for a clarification? What do we mean by innovation if it doesn't result in high performance?

MS. MILGATE: What it's designed to do is make sure that plans and providers don't just go after what they know how to do

really well, and they don't look at things that they don't necessarily know how to improve on, but they do the work to understand what the measures could be, to develop those measures, and perhaps do some interventions where they learn what doesn't work. So that would push the science of quality improvement, so to speak.

Now you could perhaps suggest that is more of a research function and not have it on the table, but it comes up often in other settings where people talk about how to do this just to make sure that folks aren't just continuing to measure mammography, for example, simply because they know how.

MS. RAPHAEL: I'm not sure what's meant by innovation but I think an example might be if someone tackles doing something across sites or across providers, rather than just in your particular domain. I think we should try to encourage efforts like that in the fee-for-service system because the handoffs are generally problematic areas. I don't know if that would fall under the innovation arena or not, but I think that might.

MR. SMITH: I think it's very hard to link in the same payment construct innovation and quality improvement. It seemed to me that the innovation issues were addressed in draft recommendation three and that if we want to elaborate on that, that's where we should do it. More resources ought to go into innovation but some innovative attempts may not produce very much, but we want to encourage that experimentation and testing.

But I don't think we want to link it to improvement outcomes.

MR. HACKBARTH: I'd like to press ahead here. The bottom line, from my perspective, is this is a case where I think we would really benefit from having a consensus recommendation with everybody supporting it. So what I'd like to do is use a series of straw votes to sort of understand where people stand on this issue.

How many favor an approach that would say that we want to reward both high performance and improvement? A show of hands?

DR. ROWE: I'm trying to understand, as opposed to what?

MR. HACKBARTH: As opposed to high performance only.

DR. REISCHAUER: No, quality improvement.

[Simultaneous discussion.]

MR. HACKBARTH: Just a second. Don't confuse me. The options I see are high performance and improvement. That was one option that seemed to have just now a whole lot of support, if not unanimous support.

A second option is performance only, just high levels of quality only. I've not heard anybody argue in favor of

improvement only as yet.

DR. NELSON: But that's what the recommendation is.

MR. HACKBARTH: Oh, good point.

MS. MILGATE: The recommendation was intended to do both, but if it's not clear, we can change it.

MR. HACKBARTH: So let's do them all.

Performance and improvement, was there anybody who didn't support that? We may be able to cut to the bottom line here. Is that what the majority or unanimously we want?

MR. SMITH: Glenn, I think both in the spirit of consensus and because I think it makes sense, that doing both is the right answer here. I am worried that we create a situation where rewards, assuming scarce resources for rewards, rewards flow to low-hanging fruit rather than to improvement and that you're right, a beneficiary is better off at 90 percent than 75 but they're a hell of a lot better off if you went from 50 to 75 than from 87 to 90. And beneficiaries don't often have choices that allow them to always end up in a 90-performing plan.

So I guess I'd be comfortable with both but with some text that made it clear that what we're after here is improvement. That we want to have everybody be high rather than...

MR. HACKBARTH: It looks to me like we've got unanimous agreement on that formulation. So let's move on.

So any other issues now about draft recommendation two and three? Or the first part of one. Again, I want to focus for a second on the areas where Karen and Mary heard a lot of agreement in our previous discussion.

MS. BURKE: Following up on Joe's point and David's point, I think the question of innovation, whether there's a way to modify three to reflect this sort of broader concept, I think makes good sense. That we ought to be rewarding people for doing things that look at things differently. So if there's a way to say that in three, to make it clear, I think it's a good idea.

MR. HACKBARTH: Any other...

DR. REISCHAUER: Why don't we just say effective and innovative mechanisms to improve quality?

DR. LOOP: Is there any merit in putting recommendation two before one and three, so that you reduce the duplication first?

MS. MILGATE: We actually proposed it that way at the last meeting and the discussion we heard was that because the central question Congress had asked us to comment on was the application of standards, that we really should put the central answer first, even though duplication does have to do with the application of the standards. That seemed to be the reason we put one first.

MR. HACKBARTH: I think that still makes sense. That is the

principal question before us.

I have a question for my education about draft recommendation two. As I read the statute, the Secretary currently has the authority to deem a private organization for HMOs and say that if you're accredited by X you've effectively met these statutory requirements. Am I reading it correctly?

MS. MILGATE: Yes, statute does say that. It hasn't been carried out yet.

MR. HACKBARTH: Where does that process stand?

MS. MILGATE: Actually, currently CMS is evaluating various private accreditor standards that have applied for deemed status for Medicare+Choice. So the discussion in the report is we think that needs to go forward and CMS should do its best efforts to make sure it is possible to deem. And then there's other discussion on broad use of deeming, rather than -- there was some concern on the part of some plans that CMS might, in fact, pick and choose standards rather than saying you've met all the standards if you meet accreditor standards that only one here or one over here.

So there's also some discussion in the report on how it should be broad use of deeming. So that's essentially what the recommendation does, is say get on with it, let's do it and make it a broad use.

MR. HACKBARTH: Okay. Anything else on draft recommendation two, three or the first part of one?

So what I take from that is that people are prepared to support those pieces as written with the amendments we've already discussed?

MS. MILGATE: I'm sorry, Glenn, can I just make sure that we decide on Alan's point?

MR. HACKBARTH: Which point, Karen?

MS. MILGATE: I think Alan suggested that talking about applying -- this was in the first part of recommendation one -- that recognizing the different plan and provider capabilities when you're rewarding high performance was redundant with the second sentence? Or should I not bring that up again?

DR. NELSON: I think you're going to be doing some rewriting based on this discussion. Also, the redundance may not stand out as much if the second part, some portions of the second part is plugged into the middle of it. So don't worry about it right now.

MS. MILGATE: So just work with your comments.

DR. NELSON: Yes.

MS. MILGATE: Fine. Thank you.

MR. HACKBARTH: So let's move to the second page of draft

recommendation number one. Let's just take the two bullets in turn.

Eliminate requirement for HMOs to demonstrate quality improvement. Here again, I have a question just for my edification. As I read the statute, there is no statutory requirement that HMOs demonstrate quality improvement. This is a requirement imposed by the Secretary, not by the Congress; is that correct?

MS. MILGATE: Yes. The statutory provision that it's linked to says, when you identify your aids for improvement, that the plan shall take action to improve. It's been my reading that what CMS did was say the way they wanted to determine compliance is to suggest you show you demonstrate improvement. One could suggest that there are other ways to determine that some entity has taken action to improve.

So yes, we believe there's regulatory flexibility for them to do that.

MS. NEWPORT: I think part of the challenge after BBA was enacted was that it was a required improvement year after year. Even though you might be at 98 percent, moving it to 100 percent or 10 percent improvement every year was an impossible standard to meet. So I want to make sure folks understand that improvement beyond a certain point in a certain area may not necessarily be achievable.

DR. NEWHOUSE: I wasn't sure from reading this exactly what we meant, but as I thought about it, what I thought we should have was that the plan would have an internally generated and approved quality improvement plan, but it would not have necessarily specific quantitative targets like the 10 percent target, and that CMS would not specify targets that applied uniformly to all HMOs. So it would be much more a bottoms up kind of activity.

I also thought we should add some language somewhere, possibly in the text, that said this did not imply anything about quality assurance activities, that we assume quality assurance remained in place.

DR. WAKEFIELD: Could you just clarify this discussion for me? Regrettably, I was out for most of the last meeting, and so I missed the discussion that might have fed into this particular bullet.

My general sense is that in an ideal world, I think that what we're trying to do is harmonize requirements to the extent possible, rather than doing anything -- unless it makes sense -- that is a step backwards or away from trying to move the field forward in terms of quality improvement, from the institutional

level, to the plan level, to the clinician level, et cetera, as tools are available to help accomplish that.

So when I see this written this starkly, it makes me really kind of uncomfortable but maybe there's something I'm missing here that supports this. Could you just give me a little background?

MS. MILGATE: The background I think is that there was the discussion, I would say, was trying to balance what you just put forth which is harmonizing the requirements that are out there and trying to move forward with quality improvement, recognizing what we do and don't know. But there was also concern that there was differences in what's applied to different entities and that perhaps it was inappropriate to have such a difference exists and would create disadvantages for some plans and essentially penalize them potentially for being good at quality improvement.

So to me that was the balance that the Commission was trying to struggle with at the last meeting. One of the suggestions was to add this in to address that unlevel playing field. But others did feel, as you may feel, that it wasn't necessarily appropriate to take that requirement off.

MR. SMITH: Like Mary, I missed -- I missed the whole November meeting, so I may be a little bit behind in the discussion. But I share her discomfort with the argument implicit in the first bullet.

Leveling the playing field is a different idea than getting the highest quality that we can get. It seems to me that, given the recognized differences in capacity language in the earlier recommendations, that having done that it doesn't seem to me, on behalf of a sort of abstract level playing field principle, we ought to say therefore we want to level down.

I think that's what the first bullet implies. I'm very uncomfortable with that, rather than the suggestion that we have different circumstances where different things are possible. And in every case, the standard ought to be as high as those circumstances allow.

I think combined with recommendation -- I guess it's now three, the second bullet does a better job of that. We may want to play with the language.

DR. BRAUN: I'm very uncomfortable with that, at least the way that it's worded, because I certainly don't think we want to eliminate a requirement to demonstrate quality improvement. Maybe it could be done through a different means than presently, but we certainly don't want that.

In fact, I think it goes against our consideration or our principles as the draft says that all plans and providers should

be working to improve quality in accordance with their capabilities. Somehow, to eliminate that seems to be just the opposite.

MR. HACKBARTH: Let's do a straw vote on this. How many would like to see this language removed? In other words, strike the eliminate the requirement for HMOs.

Joe, you said you had a modification to offer?

DR. NEWHOUSE: Yes, I'd like the requirement to be a requirement for an approved internally generated QI plan rather than a CMS-generated, uniformly applied QI plan. I mean, I think the issue is how best to get to high quality and I think this tries to address Janet's concern about getting from 98 to 100 isn't really appropriate.

DR. ROWE: I think the other -- I mean, I associate myself with Janet's concerns with respect to the diminishing opportunity for quality improvement in those plans that have done a particularly good job.

Maybe we could get there by putting a word in here that says something like to demonstrate appropriate quality improvement, or something so that it gives somebody a hedge so that if you're at 98 percent on something you're not getting dinged because you didn't increase by 10 percent the next year.

Maybe doing it Joe's way also does it but the problem is it falls out of the recommendation and is lost in the text.

MR. HACKBARTH: The message I took away from our last discussion was that many commissioners had reservations about any language in a recommendation that would look like a retreat.

DR. ROWE: Right.

MR. HACKBARTH: I understand that and in fact agree with that point of view.

The second bullet on this page, the second bullet on draft recommendation one, is actually an expansion as I see it. We are saying we need to press forward with quality improvement and do it for the institutional fee-for-service providers as well as for managed care plans.

What if we had a recommendation that said that. Then in the text said it doesn't look to us like there ought to be a quality improvement requirement only for HMOs? I don't see any reason why we couldn't say if it's good for HMOs then each hospital has to have two quality improvement projects. I don't see the reason for singling out HMOs.

We could take it out of the bold recommendation so there's nothing trumpeting retreat in the recommendation and just have a discussion of this issue in the text and have the recommendation language being press forward and expand quality improvement, not

narrow it. How do people feel about that?

Murray, I know you have some thoughts about that. Feel free to express them.

DR. ROSS: I guess my one concern would be, if you're sending an action line to the Secretary or the Congress, you should be clear what that action line is. And if it's going to be in the text, that's more discussion and amplification. So I guess I'm disagreeing slightly with that.

MR. SMITH: Jack, if we didn't try to modify bullet one, simply got rid of it, but then rewrote the second bullet so it said apply appropriate quality improvement requirements to both M+C providers and institutional providers in the fee-for-service program, I think that's both what Glenn and I were trying to get. I think it's --

DR. ROWE: I'm just allergic to the concept of eliminating anything that has to do with quality. So that's why I can't got there. I'm with you completely, Dave.

MS. MILGATE: Could I just clarify one point with Joe and Jack just to understand? Currently, CMS has retracted the 10 percent requirement for demonstrating improvement. But they still do require some improvement to be shown.

It seemed like what I heard you saying, Joe, is they should generate some of their own targets on improvement. It sort of is where CMS is. So I don't know if we could discuss that and highlight that that's a good policy. Or does it go beyond that?

DR. NEWHOUSE: I'm obviously comfortable with that, but I think it applies even more forcefully if we go into the institutional providers because what's appropriate to improvement quality at a 50-bed hospital in Devil's Lake and what's appropriate at Mass General may be totally different.

MS. MILGATE: So generalize that statement.

DR. ROWE: I think there is an Alice-in-Wonderland aspect to the conversation, in part because we wouldn't want the American public to think that MedPAC is so out of touch with reality that we think everybody is at 99 percent, and therefore we want to make sure that they're not held to an impossible standard. I think very few people if any, with the possible exception of PacifiCare, are at 99 percent of the ideal quality.

MS. NEWPORT: That's true. Thank you, Jack, for acknowledging that.

DR. ROWE: So we should recognize this is a high-class problem, if we have it, but I'm afraid we don't. I guess what we want to do is have some balance in the text or some statement about balance between the level of quality and its improvement and a recognition of the differences and capabilities of the

different institutions.

Those are the two themes that I keep hearing. One is what level are you at versus how much are you changing? The other is what kind of an institution are you? Clearly, that has to be highlighted in some way.

MR. HACKBARTH: So, Jack, could you couch your point of view in terms of a recommendation? How would you like this second page to read?

DR. ROWE: Let's go back for a second and make sure we saw what was on the first page. We have the different plan and provider capabilities taken care of, right? And we're rewarding plans and providers for exemplary quality improvement performance, right?

MR. HACKBARTH: Right.

DR. ROWE: So I think David answered the question adequately from my point of view in his recommendation, with respect to just getting rid of bullet one on this page and saying applying appropriate, or something like that. I think that does it.

DR. NEWHOUSE: Jack, would you have CMS generate the appropriate standards? Or would you have the institution generate the appropriate standards subject to CMS approval? Because the current standard it's kind of, as I understand it, one from the plan and one from CMS. And the one from CMS goes across all plans.

DR. ROWE: I don't have an opinion on that. I'm not sure. What do you think, Janet.

MS. NEWPORT: I think we set principles here. This group shouldn't go to that micro a level on this one, Joe. I would suggest if we've got some broad principles then there's licensure requirements and standards you have to meet to be a contractor and the deeming. There's lots of things there.

I'm all for eliminating the word eliminate. So I'm aligning myself with David and Jack on that. But I think there's sets of standards out there that are much broader than we've had time to even think about.

DR. NEWHOUSE: That's one reason I said I thought we should put in some language about keeping quality assurance standards.

MS. NEWPORT: Don't we have that in the other piece.

DR. NEWHOUSE: So there's no confusion about we're trying to maintain some standards.

MS. NEWPORT: But I thought that was accomplished on the first page.

MR. HACKBARTH: So what I hear is a developing consensus to take out the first bullet, not have in the recommendation eliminate, have at least in the text discussion about there being

appropriate standards or expectations of both HMO and fee-for-service institutional providers.

I'm less clear on whether people would like to see the language of bullet two change. It seems to me we can just handle it in the text and leave bullet two pretty much as is. Insert the word appropriate?

DR. REISCHAUER: Why not do what David said which is apply appropriate quality improvement requirements to Medicare+Choice plans and the institutional providers in the fee-for-service program?

MR. HACKBARTH: I think we're getting close to a conclusion. Do you want to really open up -- yes, you do. All right.

DR. NELSON: I'm agreeing with this, but I think also to slide that second bullet, with the modified wording, in between the first two bullets on the first page. It seems to me that it flows. And it reduces the redundancy in having both of them right together.

It's relatively minor, but on the other hand, it sets in the first instance what the requirements are for them to be comparable and then plugs in the concept of rewards at the end.

DR. NEWHOUSE: I think this is a text point but it goes back to Carol's point on the handoffs. One of the things the M+C plan can do that the institutional provider can't is try to coordinate across institutional providers. We have this word in this bullet that says comparable. Well, the institutional provider really can't be comparable with the M+C plan on the coordination function.

DR. REISCHAUER: We took that out.

DR. NEWHOUSE: Oh, we took comparable out. So how does it read?

DR. REISCHAUER: Apply appropriate quality improvement requirements to Medicare+Choice plans and institutional providers in fee-for-service programs.

DR. NEWHOUSE: Okay. There's going to have to be a lot of text language on that.

MR. HACKBARTH: I think we're at the point of diminishing returns on this discussion. I think that Alan's point about the order is a good one. That it flows nicely if we take the remaining bullet from the second page and insert it in the middle.

So as I understand it, it would be the Secretary should recognize differing plan and provider capabilities. The Secretary should apply appropriate quality improvement requirements to both M+C and institutional providers in fee-for-service. And the Secretary should reward plans and providers for

exemplary performance and improvement.

So I think that's the proposal on the table, with maybe a little editing here and there. Let's do a straw vote.

DR. WAKEFIELD: Real vote.

MR. HACKBARTH: I want to go back and do them all, but I want to make sure that I'm not missing something. Is what I just said what people want to do on recommendation one? All in favor of that approach? Looks like we've got agreement.

Okay, so why don't we go back and do our official votes? Have we covered everything from your prospective?

MS. MILGATE: The one dangling question I have is the reason we took out comparable was to just have a broader ability to discuss what's appropriate for one or the other; is that correct? I want to just clarify that. Because the purpose of that second one, at least at first, was the comparable.

DR. NEWHOUSE: We said the Secretary should recognize the difference. So in some sense, it then creates...

MS. MILGATE: There was a little bit of a distinction I heard, though, in terms of those that started high and those that started low, and that that should be applied broadly across. I think that there is enough of a distinction.

MR. SMITH: I think the other thing we were trying to do there is emphasize the quality improvement ought to apply in an even-handed way, rather than the level playing field.

MS. MILGATE: Fine. Okay.

MR. HACKBARTH: Okay, let's do our votes. So all opposed to draft recommendation one as amended?

All in favor?

Abstain?

Draft recommendation two, all opposed?

All in favor?

Abstain?

And number three, opposed?

In favor?

Abstain?

Okay, we're done.

DR. ROWE: Glenn, can I make a comment with respect to the text of this chapter for our long-suffering staff, before they depart?

MR. HACKBARTH: Sure.

DR. ROWE: In trying to read this over again with a fresh view, which is not easy after all these discussions, it struck me that in the beginning of this there's a statement which is really at the nub of much of our discussion that says that a concern about appropriate application of M+C quality improvement

standards to different types of plans and the differences in quality improvement efforts between fee-for-service and M+C.

And then you have to get to page 23 before you find out exactly what the differences are in the rules. Because then we go into the quality problem and everything else. We're assuming that the reader understands what the issue is that we have been grappling with of this unequal playing field issue.

So I think that some of the stuff that's on page 21 and 23, particularly the stuff in the middle of 23, there's one paragraph that really explains this difference, should be moved up. That would help the reader understand why is it, what exactly are we thinking about. And then, when we get to the recommendations, it sort of ties together.

It's a minor point, but I think it would be helpful.

DR. WAKEFIELD: Just also a couple of comments of the text, and I'll give you my notes. I like the fact, of course, that you reference periodically AHRQ and its role here. Clearly, I think that this is where AHRQ is the science arm of this endeavor. CMS -- at least it's my view, maybe even in broader areas but in this area, I think especially -- is somewhat underresourced. So to the extent that we can say here is the entity that can do the evaluation on the demos that might get done, or at least ought to be working with them to do the evaluation rather than having CMS, for example, create the demo, implement it, and maybe evaluate it solo.

So wherever we see AHRQ or an evaluation research component, I think that's a lot to put on CMS. I think the only place where it surfaced, at the last meeting before I walked out, was on that one point about CMS' capacity. I think that's a really important one.

We really ought to drive that point home about the role that AHRQ can play, as not a regulator but on the science side.

Also, you might want to mention, too, that AHRQ has been in the process of developing, with CMS, a CAHPS version for fee-for-service that's going into the field now. AHRQ has been working with CMS, they're not in the field by any means, but to develop a CAHPS version, a CAHPS-like instrument for nursing home related evaluations. I think that's worth nothing.

I also think it's worth nothing that when you talk about JCHO, JCHO and CMS have pretty much now reached agreement, I think, on some core hospital measures. That's going to drive a lot of what the National Quality Forum does in this area. So there certainly are some wonderful progressions that are occurring on this front.

And because you discuss these areas, that feeding some of

this -- this is what's -- we're on the cusp of in those different areas is probably worth noting, and I'll give you my notes on it.

MR. HACKBARTH: We're done. Thank you, Karen and Mary.